

Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2016
NAME OF PROVIDER OR SUPPLIER MCMINN MEMORIAL NURSING HOME & REHA		STREET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH ETOWAH, TN 37331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A licensure survey was completed on 5/31/16 - 6/3/16, at McMinn Memorial Nursing Home and Rehab Center. No deficiencies were cited under Chapter 1200-8-8, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

30TH11

ADMINISTRATOR

6-21-16

If continuation sheet 1 of 1